Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Center for Pain Management

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-13-2903-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Per conversation with Margaret appealing claim with J2275… "

Amount in Dispute: $1,458.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed the billing and the coding, and declined to issue payment due to incorrect coding for the morphine. The requestor appealed the denial twice without changing the coding or offering an explanation for maintaining an incorrect code. Per TrailBlazer Local Coverage Determination policy in 2011 all drugs, whether single or combined, used in an implantable infusion pump must be billed using code J7799-KD."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 4, 2012	Drug infused via intrathecal pump	$1,458.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission requirements for health care providers
3. 28 Texas Administrative Code §134.203(b)(1) sets out medical fee guidelines for professional services
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 714 – Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Services are not reimbursable as billed.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Did the requestor submit the medical bill in compliance with Division and CMS rules?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Oklahome to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. 28 Texas Administrative Code §134.20(b) (1) states, in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; …and other payment policies in effect on the date a service is provided…" Review of the documentation finds that morphine was dispensed and billed under code J2275. The Medicare policy in effect for the dates of service in dispute may be found at http://www.novitas-solutions.com. CMS Manual Publication 100-04 Medicare Claims Processing, Transmittal 2132 which states, in pertinent part, that the local contractor sets payment policies for drugs used in an implantable infusion pumps. At the time these services were rendered, the applicable billing instructions were found in the LCD for *Implantable Infusion Pump, L32740,* published by Novitas. Novitas instructed providers to bill in the following manner: "…Note: Use J7799KD to indicate compounded and/or combination drugs used in implantable infusion pumps including fluxuride, morphine sulfate, hydromorphone, fentanyl, compounded baclofen and ziconotide, ziconotide and opioids, clonidine (Duraclon), Sufentanil, methadone, and bupivicaine. Other drugs are not covered." According to the Medicare contractor's billing instructions, this medication should have been submitted with J7799KD. Reimbursement cannot be recommended as the medical bill did not meet the billing requirements of the applicable Medicare policy.

3. The requestors' medical bill did not meet requirements of instructions detailed in 28 Texas Administrative Code §134.203(b) (1). For that reason, payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that any reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined no additional reimbursement for the disputed services is due.

Authorized Signature

		June , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.